Certification/Adoption Workgroup
Draft Transcript
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Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Great. Thank you very much, and welcome, everybody, to the Adoption/Certification Workgroup call. Just a reminder that the public are on the line, and there will be opportunity at the close of the meeting for public to make comments. Workgroup members, if you could please remember to identify yourselves when speaking. Let me do a roll call now. Paul Egerman?

Paul Egerman – eScription – CEO
Yes, I'm here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Marc Probst?

Marc Probst – Intermountain Healthcare – CIO
Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director
Rick Chapman?

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Adam Clark?

Adam Clark – Lance Armstrong Foundation – Director for Health Policy
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Charles Kennedy? Latanya Sweeney? Steve Downs? Steve said he couldn't make it today. John Glaser will be joining late. Scott White? Micky Tripathi? Larry Wolf?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I'm on.

Judy Sparrow – Office of the National Coordinator – Executive Director
Joseph Heyman? Okay. With that, I'll turn it over to Paul Egerman and Marc Probst.

Paul Egerman – eScription – CEO
Thank you very much, Judy. This is Paul Egerman. This is our scheduled workgroup conference call for the adoption/certification workgroup. It turns out this is the first workgroup call that we've had that's been

open to the public. So I just want to repeat the comment that Judy made earlier that we request everybody, when they speak, to say their name first.

What we're going to do for an agenda, the agenda originally had three components. We wanted to, number one, discuss what comments we want to make on the IFR and the NPRM. Number two was to discuss our future plans, our plans for future meetings relating to adoption. Number three was to discuss the upcoming patient safety hearing.

Agenda item two required the discussion of future plans for adoption required a fair amount of assistance from the ONC staff, and I think, as we all know, Washington, D.C. got a gazillion feet of snow and, as a result, the federal government, in D.C. at least, has been shut down the last few days. So they were unable to do the preparatory work. What we're going to do is going to skip that agenda item. We're really going to talk about two things: one is our comments, and the other is the patient safety hearings, so we'll defer the future adoption plans to another meeting.

I think, as a result, we had originally scheduled this call for three hours, to run from 3:00 to 6:00. Most likely we won't need that full three hours. We'll probably end up finishing at 5:00. The way Marc and I are going to do is, I'm going to do the first agenda item, the comments, I'll lead the discussion on that, and then Marc will lead the discussion on the patient safety hearing.

On the issue of the comments on the NPRM and the IFR, I just want to also make sure that we're sort of grounded in how all that works. Basically the public, any member of the public, can and should make comments, and there's a vehicle to do that on the Web site. We have been asked, we being the workgroups, have been asked what comments we want to make relative to the work that we have done so far. And the comments that we make will get reported at the policy committee meeting next week, which is in, I think, actually six days, February 17th. If there's concensus among the policy committee, that will be also the official comments from the policy committee that ONC will use as input into their decision making process. That's where all that standards.

I want to start talking about what comments we want to make, but let me pause a minute to make sure that what I said made some sense and I wasn't on mute the whole time. Does anybody have any questions or comment about the agenda so far?

Joseph Heyman – AMA – Bord Chairman
This is Joe. I got on a little bit late. Did you say we were going to leave the discussion about adoption to a later time?

Paul Egerman – eScription – CEO
No. Yes and no. First of all, that's Joe Heyman speaking. Two things: one, Joe, is that because our meetings are now in the public, we want everyone to say their full names before they talk.

Joseph Heyman – AMA – Bord Chairman
I apologize.

Paul Egerman – eScription – CEO
Not a problem. What I'm saying is agenda item number two was originally our plans for how we were going to do deal with monitoring and providing advice on adoption. When we look at agenda item number one, which is comments we want to make on the NPRM and IFR, any comments related to adoption are certainly very reasonable to make, sir. And the reason, just to make sure everybody understands why Joe makes this comment is, what happened there was, as I sent out these e-mails about some

suggestions I have to help sort of stimulate our discussion about certification, and Joe sent back an important e-mail and said, why don't we look at this and this because these are barriers to physician adoption. Somehow I was in like a certification mode.

I said, what does that have to do with certification? He reminded me, we're not just certification. We're adoption. Those are completely relevant comments, and so what I thought I would do is structure our discussion by first looking at the IFR and the certification piece, and then we would look at the issues that Joe wants to raise that are relative to adoption, and then, of course, whatever other issues the workgroup members want to raise. Is that okay with everybody?

Joseph Heyman – AMA – Bord Chairman
Absolutely.

Paul Egerman – eScription – CEO
Great. Rightly or wrongly, I sent out this e-mail with some of my initial thoughts about first the IFR. Again, one important thing that I want to say is, as we make comments about the IFR and NPRM, my comments are not necessarily required to be criticisms. I think it's probably very important that that ONC and CMS hear things, places where we're very happy with what they're doing. They probably need to hear that also.

I thought I would start the discussion on the IFR, which really has dealt primarily with standardization and certification with what we think are positive steps, what are the things that we liked about it. I personally listed three things. I listed the fact that there is the vocabulary or nomenclature standardization, which is really a form of LOINC and RxNorm. The modular approach to an EHR was the second thing I listed. Then the third thing I listed was I liked the reasonably current, advanced technology, you know, REST, SOAP, and XML that were used. I wanted to hear what reactions people had to that, if they think that's reasonable or if that's not reasonable or if there's something else, any comments.

Does silence mean everybody likes it, or is everybody on mute?

Let me ask you, Rick, Rick Chapman, do you think these are positive steps forward?

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
As a matter of fact, yes. I was actually studying. This is Rick Chapman. I was studying some of your comments about some of the standards that were proposed in the IFR. I don't have any particular criticism of the ones that were put out there, but I know there is discussion. But I don't have any specific comment about them.

Paul Egerman – eScription – CEO
Okay. The question I have is the … first part of this is the positive steps. I'm putting forward that, for example, standardization of nomenclature of vocabulary, particularly designated LOINC and RxNorm for exchange transactions, that I think that's a major step for interoperability. Do people agree with that? Should that be part of…?

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
This is Rick Chapman, and that's one I was speaking about. Those look fine to me, and I would certainly agree with your comments.

Paul Egerman – eScription – CEO
Then the other one is the modular approach to EHR. The third one is the technology buzzwords.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
On the second one, Paul, I would certainly agree with you. I think we've heard a lot of positive comment about this modular approach, and I think it addressed a lot of negative perceptions that were out there. So I believe this has been very positive. On the third, that's what I was talking about. I don't know that I know enough about those to comment more. They seemed to be fine, but I believe Larry Wolf is on the call. Larry, did you have any comment about these?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
My question, Paul, was those technologies you cite had been in use in terms of general applications for a while. Was there some reason you wanted to identify them specifically as advanced technologies?

Paul Egerman – eScription – CEO
Maybe the word advanced isn't correct. They are identified in the IFR. Certainly SOAP and REST are, and there's actually a fairly long discussion. When I first saw this, actually I made a comment about this at the policy committee meeting. My comment was that I thought that the IFR was buzzword compliant, which actually I realized later had sort of like a negative connotation. But it really means that you're using technologies that are actually in common use. It's not leading edge stuff. It's more like this is where the state-of-the-art is. At least that's my impression. I don't know if you agree with that, Larry.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
No, I do agree with that, so maybe that's actually a better way to state it that they're supporting the mainstream technology because there's also a mix of version 2 HL-7 technologies, which are not XML based.

Paul Egerman – eScription – CEO
That's true.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
So I think, in general, everyone is trying to find a balance between trying to move ahead with technologies and finding ones that are actually in production and getting a lot of use.

Latanya Sweeney – Laboratory for International Data Privacy – Director
This is Latanya. I actually had some feedback from some of the vendors and some of the providers recently, actually about confusion and concern. The confusion and concern is because there are so many variations of standards that could be used, and they're afraid that – some are afraid that they have to implement all of them, and others are afraid that they'll choose a subset to implement that won't serve them in the long run.

Paul Egerman – eScription – CEO
Yes. It's a good comment, Latanya. That sort of leads to some of the issues when we get to the second area in terms of standards and specificity. In terms of the technologies though, those aren't really standards. Those are just technologies. Although I guess the point that Larry is making is there are multiples of those also. I think that that makes sense. Are there other comments about things that we like before we talk about some of the things that we're concerned about?

We'll move to the second area, which picks up a little bit on what you just said, Latanya. First, in my memo, I made two observations. One was that our recommendations were that there should be greater specificity in exchange standards in order to achieve interoperability. That's what we said back in August. Again, I think this is what you're saying, Latanya. I didn't see the greater specificity. In fact, I saw a lot of

places where there were choices of standards and even indications in the future there might be other choices, and so that had me concerned. Do people agree with that?

Latanya Sweeney – Laboratory for International Data Privacy – Director
I definitely agree that that's a problem in terms of achieving interoperability is a problem.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Yes. I certainly agree with that too. I think Latanya is right out because we allowed at least two standards, one of them being a text based and the other being more of this HL-7 continuing continuity of care, I think, which seemed to have at least more granularity. But I think, given all the complexity of the interchange that we're talking about, that more exact direction would be better.

Paul Egerman – eScription – CEO
Now the one you just mentioned, Rick, was really the CCD versus CCR standard, which was like a political—

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
To tell you the truth, I didn't really mean to make that direction. But the fact is, pick one, and at least then we're more detail oriented, and we could use them. The fact is, like Latanya said, do you have to use one or all or just one. I think we should have been more specific. I'm not endorsing one or the other, is what I meant to say.

Paul Egerman – eScription – CEO
We'll talk about that more in a minute. The other general comment that I made in my e-mail was the relationship, dealt with the relationship between the NPRM and the IFR. Now the NPRM is where meaningful use is described, and fundamentally the IFR, which is where the certification criteria is described. The way I look at it is everything that's in meaningful use really has to be in the IFR because the certified software, the certified systems have to be able to do whatever is described in meaningful use. So it makes sense that what's in the IFR, what's in the NPRM is in the IFR.

But what I'm trying to say in my next couple sentences, the opposite does not need to be the case. You can certify other things, especially if it relates to privacy, security, or interoperability that aren't in meaningful use because interoperability is its own, you know, it's own basic function in the legislation. That's just a general comment.

Now moving on through my e-mail—

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Could I just ask a question about the CCR, CDA thing?

Paul Egerman – eScription – CEO
Yes.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
It seems to me that if you want to have this be meaningful at all, you can't choose just one or the other unless you prescribe the use of the other because if I've chosen the CCR, and everybody down the street is using the CCD, I have to at least have the ability to import the CCD, and they have to have the ability to import the CCR. Otherwise, what's the point?

Paul Egerman – eScription – CEO

You're 100% right, I think.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Right. That was why you get to these things of the manufacturers getting worried that they have to implement them all.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Exactly, and I think that unless somebody chooses between the CCR and the CCD, and says you can only use one of them, then we sort of have to insist that you may only have to create one of them, but you need to be able to receive both of them.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I think that, in fact, that's what the IFR says that you have to be able to import either.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Okay.

Paul Egerman – eScription – CEO
Yes. It does create a situation where – this is Paul Egerman, but picking up on what Larry just said. It does create a situation where, if you're a software vendor, that means you have to be able to receive either, receive both of them.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Right.

Paul Egerman – eScription – CEO
It's a little bit extra work, although I think the IFR does a pretty good job of saying what you're supposed to do. I think the CCR says you have to just display the text, if I remember it right. But I don't know if people agree that it does a pretty good job. But when you specify too, it means you have to be able to receive both of them, and you have to test both of them, and that is a burden. And it may not be bad on a single interoperability issue or a single interface, but if you were on too many of them, I think it becomes problematic. It could be almost like a matrix of all the different possibilities of what could occur.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I agree.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Paul, this is Rick Chapman again. Back to your comment that you were going on between the fact that we've not issued the NPRM for the certification process. Could you kind of go over that again because I think you're on to something here when I read your first e-mail, because you put a question to us that maybe we should repeat our earlier recommendations just to make sure that the two are not out of synch, which I think is what you were at least beginning to explain a while ago. You wanted to make sure that the two were in synch.

Paul Egerman – eScription – CEO
Yes. I want to get there, Rick.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Sorry. I thought you were already going down that track.

Paul Egerman – eScription – CEO
No. It's a good issue. To make sure everybody understands the issue that Rick is raising is, we have an NPRM that's already been published for meaningful use. We have an IFR, interim final rule, that's been published that describes certification criteria, standards, and things related to basically the software and the technology. But what we don't have yet is a rule, an NPRM for the actual certification process. This was the recommendations that we made about an accreditation organization and the entire process. The absence of that was creating some anxiety. What I want to do is let's finish talking about the IFR. Then we'll get to that piece, Rick.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Okay. Sorry.

Paul Egerman – eScription – CEO
We have these comments that basically we would like to see greater specificity. The next series of things I put in my e-mail sort of relate to that because one of the areas that is particularly important actually in – it's important in the NPRM for meaningful use is the ability to electronically receive laboratory results. It's also, I think, a fundamental interoperability problem that exists is the difficulty of getting meaningful laboratory results, and this difficulty of getting lab results is particularly tough in my observation for actually small medical groups.

Sometimes small medical groups have to interface with multiple labs, and they get frustrated. It's an understatement, the difficulty. The issues that I saw there were in the IFR. There is a specification. Unfortunately, there is a single specification. It specifies HL-7 2.5.1, which is a mouthful, but that's the thing to be used when hospitals or physician groups transmit lab results to public health agencies.

One comment or recommendation that I would like to suggest that we make is to say, well, if we're saying that you're going to use that, that's what hospitals use when they submit to public health agencies, well, then, that's also what hospitals should use when they submit lab results to physician groups because a lot of physician groups don't get their lab results necessarily from an independent laboratory. Lots of times they get it from a community hospital. And so, the thought process I had here was really to say, well, the IFR specifies this interface for a purpose, which is submitting labs to public health agencies. That means the software vendors have already got to do the work anyway. Why can't we certify it for this other purpose, which would help us, actually help us a fair amount with the interoperability issues for lab results. I don't know what people think of that comment.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Paul, this is Rick Chapman. Are you talking about inpatients who are currently being seen by a physician, and they're sending lab results back? Are you talking about health information exchange, or both?

Paul Egerman – eScription – CEO
It's more of a health information exchange. What happens is, in a lot of environments, especially where there's community hospitals, a medical group, a physician group, the way they get some of their lab results done is rather than have a contract with an independent lab like Quest, they'll have a contract with the local community hospital. They'll draw their samples, or they'll send the patient to the hospital for their samples. They're get the test results, then the hospital then has to send electronically back the results to the medica group.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
If that's the case, well, wouldn't the IFR specify a standard, that HL-7 standard you referred to? Wouldn't that apply to that community hospital in that regard?

Paul Egerman – eScription – CEO
That's what I'm proposing because….

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Our interpretation is it may or may not, as it stands, and that we need to make that clear. That's really what you're saying.

Paul Egerman – eScription – CEO
What I'm saying is that, yes, it doesn't tell the hospital what they're supposed to do under those circumstances. If you certified the software so that that's what it had to have the capability of doing, then any physician group that contracts with any hospital, as long as the hospital has a certified software, that they will have that standard interface to send the lab results.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Again, I would certain, for one, agree with that in that since you're functioning as a reference lab, be it a reference lab or a community hospital, the same standards should apply.

Joseph Heyman – AMA – Bord Chairman
Believe me, my understanding of all of this technology is on a very, very basic set up, mainly as a user. But I can tell you that when we tried to set up our health information exchange in my community, we have a hospital that uses MediTech, and they had an index for all of their laboratory stuff, and I don't know whether it's LOINC or not. Then we had to mesh that index with the index of the vendors that had EMRs in the community, and it was not an easy task to do. I mean, I think, at minimum, we ought to at least know from vendors whether or not this is something that's doable. I mean, if it is, and if you guys tell me it is, of course I'll go along with it. It's certainly a lot better if everybody is using the same standards to transmit data.

Paul Egerman – eScription – CEO
Yes. First of all, there are two comments here about this issue. And they both address exactly what you just described, Joe. There's one on the hospital, which is really on the sending side. And there's one next on the receiving side, but the basic concept is, yes, it's doable. And they actually, in the IRF, already specified a standard or a specification as to how you transmit lab results to public health agencies from a hospital. We're just saying, use that exact same standard to transmit it when it's to physician groups, when you transmit it. You used the example of MediTech. The idea is, if we can get everyone to use the same standards to send and receive, and we get everyone to use the same terminology, which is called LOINC, I can't tell you that we make these things completely plug and play, that they just snap in place. But I think there's got to be a giant step forward. In other words, the amount of grief that you go through in getting a lab interface done should be reduced by the two-thirds, three-quarters. I can't tell you it disappears 100%, but I think it would improve a fair amount.

Joseph Heyman – AMA – Bord Chairman
I also remember vaguely the discussion about some of the laboratory work not being included, not having a place in LOINC. I think that, you know, I agree with 100% that if there's one standard that we can use, and that everybody can use, that's a good thing. But I also agree with you that there'll probably still be some problems because … not covered.

Marc Probst – Intermountain Healthcare – CIO
Paul, this is Marc. Sorry.

Joseph Heyman – AMA – Bord Chairman
That's it. I'm sorry.

Paul Egerman – eScription – CEO
Go ahead, Marc.

Marc Probst – Intermountain Healthcare – CIO
Paul, all I was saying is I like the concept of certifying the capability. What I'd hate to do is have it state that everyone has to communicate that way to be certified. In other words, there's a lot of current communication of lab results from hospitals or other entities to providers that's currently working. And so, I think there's a difference between the capability and actually certifying that that's what they're using right now.

Paul Egerman – eScription – CEO
That's an excellent point, Marc. I agree with that point. In other words, all this is to say is to certify the capability. Meaning, if you're a purchaser, if you're a hospital, and you purchase one of these systems, it'll have the capability to send the lab results in this was. You might never use it because maybe you don't ever function as a reference lab kind of function, so you never use it, but it's just to have the capability.

It would not require you to redo existing interfaces either. In other words, if you've got something that works, sort of like you've got a million other things to do, and right now you don't want to screw around with it. And so it wouldn't cause you to redo the existing interfaces. It's only a capability for the stuff that's going forward.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Paul, this is Larry. Let me … continue to shade that distinction between capability and use. I agree with you that the capability needs to be there so that we can move forward. The concern I've got, and I think Marc was alluding to this, and it's what's behind Joe's frustration trying to create the interfaces is those existing systems, not the software, but the implementation at that particular provider, has chosen a vocabulary to define their labs with, and they didn't choose LOINC. They chose some local vocabulary.

Paul Egerman – eScription – CEO
Yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
And now they're going to be generating. Now every facility needs to take on the task of creating and maintaining mappings to LOINC or redoing their internal vocabulary to LOINC, both of which are ongoing projects. Converting is probably a very big project. Maintaining the mapping is certainly an ongoing project. That sort of effort is much bigger than just vendors' capability and likely actually would stretch vendor capability to imbed these mapping tables in a way that would be maintainable, both for the vendor to create the capability, and for the providers to maintain the mapping.

Paul Egerman – eScription – CEO
Yes. I understand that issue. If I'm hearing you right, Larry, the issue you're raising is, well, how practical is this because there are like 10,000 different labs, and we're talking about LOINC, and how are we going to get from where we are now to how we map everything to all 10,000. Is that right?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yes. I want to head us in this direction, so I'm raising this as an obstacle we should address, not one we should stop with

Paul Egerman – eScription – CEO
Yes. That is addressed actually in the implementation guide. If you look to what I wrote in 2B, it says we recommend adoption to the implementation guide for HL-7 2.5.1. The way it's addressed is in the universe of whatever it is. However many thousands of lab results, there is a smaller number, maybe 100 or 200 that represent 98% of what's normally ordered. The first step would be just to do that smaller universe. The idea being, if we can get the mapping done for the first 98% because the number 200 is not a big number in data processing.

You can do the mapping on that in a reasonable time period. That would be a big step forward. It doesn't do everything, but again, if you're a community hospital, you're dealing with a physician group who could very well do much more than 98%. It might do 100% … do much more, but even just 98%, that's a big step forward. Did you understand what I--?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Yes. I do. I guess I'm thinking about is we're really addressing multiple audiences here, so we're addressing a vendor audience in terms of software capabilities, and that's what most of the certification discussion has focused on. We're also addressing a provider implementation activity, ongoing operations activity to use those vocabularies and to create internal transitions of some kind because they're likely going to have their existing lab systems and their existing interfaces they need to keep going, as well as support this new capability. I'm not saying we shouldn't do it. I think we should acknowledge that we're addressing two different audiences here and two different constituencies who are going to have to do some work to make this all come together.

Paul Egerman – eScription – CEO
Well, yes, and I think, actually, Larry, that's an excellent point. I think it's one of the reasons why, when we start discussing these things, there's sometimes a lot of confusion because I am thinking about it from a certification concept, which is to simply say, we want to get – we want new purchasers of these systems to have these capabilities. What we're hoping that does is that lays the groundwork for greater interoperability.

But while we think about it in those terms, other people think about it from the viewpoint of, well, I'm the provider. How is this going to work right? I'm the hospital. How is this going to work right? And taking it from those viewpoints, they think of the very practical issues like the practical issue you said about LOINC, which is, well, it's easy it is for the first 95% or 98%, but it's a bear to do for the rest. And so certainly there's no expectation, at least not on my part, but maybe it could be on others, but by doing this you 100% solve the problem. But the goal is not to solve it, but to improve the situation significantly.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I think, you know, lab is an interesting example because there's a very high implementation of lab systems in hospitals today. So it's not so much a question of putting in a new lab system inside the hospital. It's going to be upgrading or modifying one that's already in place. …EHRs is widely adopted, but there are certainly … adoption of lab systems.

Paul Egerman – eScription – CEO
That's true. But the lab interface is already in the IFR for reporting lab results to public health agencies.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right.

Paul Egerman – eScription – CEO
So, at some level, it has to get done by the hospital. I'm saying, since it's already there, let's repurpose it for this other purpose.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Yes. It would be great to be able to get reference labs of whatever flavor, outsource labs whatever flavor, to generate the results in a single vocabulary with single messaging and single implementation guide. It would certainly make all go-forward projects a lot simpler.

Paul Egerman – eScription – CEO
Yes. It would be great, although the reference labs are not sort of like under our umbrella. In other words, they're part of this other thing called CLIA. If we deal with the community hospitals, which are under our umbrella, and do represent a very high percentage of the work that's being done for physician groups, I think that starts the process.

We've had a discussion about … because it's somewhat technical, perhaps there's a little bit of confusion about it. But I'm not hearing anybody objects to what I wrote here for that as a recommendation. In other words, am I hearing somebody say that it's a bad idea? They don't think this is the right thing for us to be doing. Is that correct?

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
I think so.

Paul Egerman – eScription – CEO
Okay. So then, the next point of what I said was, this is actually the way I read the IFR is even though it talked a lot about LOINC, it didn't really specify a standard or a certification for physician groups or hospitals. It's really an issue mainly for physician groups to receive lab data, which actually had me surprised. I didn't know if I just read it wrong or if it was just an omission. But it just seems to me there ought to be a standard for that, especially since it's required for meaningful use, and they just use the same standard, 2.5.1. I don't know if maybe somebody at ONC tell me I read it wrong, and it really is there somewhere. I just didn't see it.

John Glaser – Partners HealthCare System – VP & CIO
Paul, this is John Glaser. It's been a while since I've looked at that darn thing, so I don't recall whether you're right or wrong. Even if you're wrong, it wouldn't hurt to have that as a comment, in which ONC can say, well, it's already in there. Not to worry. But I would agree with you. I would just include in the comments again … whether it really in there or not.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
I agree too.

Paul Egerman – eScription – CEO
The other comment I made, John, is about the implementation guide. When you read the IFR, there was someplace where it asked for public comment because it said they didn't see any implementation guide that was in widespread use. The more I look at it, though, is if there's an implementation guide that was already in widespread use, we wouldn't need the government to specify one. The reason we need the government to specify one is there isn't an implementation guide in widespread use.

And so I kind of thought that perhaps there was some logic that wasn't quite right on how they decide whether or not to specify an implementation guide. It's because we have so much confusion about how these interfaces – what is the correct standard for the interface and what does the interface … really means, that I think there's a significant reason to adopt an implementation guide.

John Glaser – Partners HealthCare System – VP & CIO
Yes. We around on agree to what you want implementation guide. There's both a power and problem with rules. The power is the rules, and you've to comply with them. The problem with them is they're slow to change. I mean, just the, you know, as you guys are witnessing, getting the certification process out is a lengthy undertaking every time you do a rule. So to the degree that implementation guides are really evolving rather rapidly, you don't want to put them in the rule because the rule will submit things, and so it gets tricky about how you handle that.

So anyway, we went back and forth about, on the one hand, you want to put them in there because it … to people. On the other hand, you don't want to put them in there because it quickly becomes yesterday's news. I think what we're going to have to do is … this settled, which it will shortly, is start issuing through guidance, implementation guides and specifications. In theory, they're more voluntary because they're guidance rather than a regulation. But that would allow that to evolve a little bit more rapidly than rules are capable of evolving.

That's why there's, in some cases, there weren't implementation guides because there weren't. In other cases, there might have been, but we're kind of hesitant to put them in there for reasons of not wanting to cement stuff. It needs to be more fluid than that.

Paul Egerman – eScription – CEO
John, what should we do? Should we just avoid the whole issue of implementation guide, or should we make a recommendation that there be guidance on it? What would you suggest is the right thing?

John Glaser – Partners HealthCare System – VP & CIO
You should say the recommendations that, appreciating the challenges, that we need implementation guides because that's where we take, you know, even standards, which have lots of options in them, and really help the field narrow it down. And you could say there may be multiple ways that the government can pursue this. They can pursue this through guidance or regulation or through ongoing presentation and … that standards … policy committee. But I think it's fair to point it out, and need not feel like it's got all the comments have to be strictly confined to I change this portion of the rule or that portion of the rule. You could point out collateral stuff that needs to be done that centers on the rule, but may not be the rule itself.

Paul Egerman – eScription – CEO
Okay. That makes sense to me. We keep moving to this conversation in my e-mail. I made these two comments about the laboratory, which … specify interfaces. The other comments that were in the e-mail were … letter C that speaks to the issue that one of the issues that indirectly that you raised, Latanya, which is there's a place for a submission to public health agencies for surveillance that listed two standards, and it also was the two standards for submission to immunization registries. What I was going to suggest is that there be either only one standard adopted for each, or alternatively, if there's going to be more than one, that there be basically more clarity, some description of the circumstances under which each specification should be used. I don't know if people have any comments about that. Does silence meet people agree with that, or silence mean that – I guess so.

M

…silence is probably ignorance.

M
That was going to be my point.

Paul Egerman – eScription – CEO
It's so detailed, you have no clue what it is. That's okay. I'll write it down, and if it turns out it's wrong, somebody who knows much more will … completely reasonable reason why it was done that way, and so not to worry.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Paul, sorry. I think it's actually a good question to seek for some understanding about why the multiple standards were proposed.

Paul Egerman – eScription – CEO
Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Because I think my ignorance is not around what you're quoting, but why the different ones would be put forward.

Paul Egerman – eScription – CEO
A better way to express it maybe would be to say we want specificity. And when there are two, we want an explanation as to where there's more than one.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
And, if possible, a roadmap or even a process to a roadmap.

Paul Egerman – eScription – CEO
That's very help.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
…multiplicity.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Yes. This is Rick. I think that's a better approach, and it just raises the question in general about a number of areas, and I think you're onto something, Paul.

Paul Egerman – eScription – CEO
Yes. Actually, I think those are great comments, a great comment, Larry, because there may be some very valid reason why there's two here, and we just don't know what it is. And so all we need to do is hear why it is. The main point we want to make is the point that Latanya made earlier is we really want to have specificity. We don't want to have a lot of choices in this. But maybe sometimes there's a reason why, so that's helpful.

Moving on, the other comments I made, the IFR permits modular EHR solutions, which we think is great. However, what I said, in order to achieve modularity, additional exchange standards will probably need to be specified. And I recommend that ONC should request public input on which additional exchange standards should be identified for stage two.

Marc Probst – Intermountain Healthcare – CIO
Paul, this is Marc. Are you referring to the ability for different components that create this module solution to communicate with one another?

Paul Egerman – eScription – CEO
That's right. That's right. In other words, by even asking the question, I'm also putting the exchange discussion to a slightly different ballpark because, up to now, I think we're looked at exchange as how does an organization communicate outside its walls. In other words, how does one healthcare organization communicate with another healthcare organization? But my view is we're really going to support modular solutions if we're really going to have this view that patients can get access to things on their iPad or their PDA. If people are going to build all these other solutions, there's going to have to be a lot more interfaces and specification as to how that's going to happen.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Paul, this is Rick Chapman. I don't know if I agree with you or not on this one. At least, or else I don't understand it, which is probably the case. I think, a modular solution, to the extent that inside the walls would be a fiscal or virtual of a hospital or physician EHR. I don't know that we need to be more specific on how they connect to each other because I think we have an umbrella set of regulations around meaningful use and through health information exchange between institutions that would cover it I think it's a superset. I don't know, and I believe that's what you're saying. Maybe we should go inside the walls. But I don't know that we haven't addressed that by talking about between parties.

Latanya Sweeney – Laboratory for International Data Privacy – Director
This is Latanya. When I think about the modular approach, I think about my computer system being able to have a file system where I can load files using different programs. Certain programs can read a DOC file or a PDF file and so forth. That works because there's a standard in which the data is stored there. The idea of the modularity is to provide some competition in the provider's machine that, hey, here's a better program for this kind of disease management or whatever the issue is. That's what I think of when I think of modularity.

I think that your point, Paul, is excellent to remind us that we've got to have some kind of standard if you're going to achieve that. But I'm not sure that it has to be an exchange standard because it could just be a file storage standard.

John Glaser – Partners HealthCare System – VP & CIO
Yes. This is John Glaser. I think you guys have wide latitude in which you choose to comment on. A couple considerations: One is, the legislation was centered on interoperability between organizations and not centered on integration within. To the degree we start going within, we're going beyond legislation, which can be fine, but can actually reduce ONC's ability to affect it because it will be accused of operating outside of legal boundaries, so to speak.

The other concern that came in was realizing that lots of places, and I happen … that I know Marc does, as does other. Internal systems, which are glued together, because what you didn't want to do was get to the point of sort requiring these standards internally because this tight timeframe just became impossible. It may already be impossible, and to try to avoid getting entangled in the internal. …avoiding … pick four modules, that those modules would be well integrated … caveat…. Again, I think you've got to have latitude on commenting. You should probably just bear in mind of at what point do we leave the legal boundaries of ONC, and to be careful that we don't get into regulation of internal communication and just cause costs and timetable to go higher than would like them to be.

Latanya Sweeney – Laboratory for International Data Privacy – Director
John, this is Latanya. Let me just get some clarification. I thought Paul was responding to the module approach that has already been put in the current text, and then trying to clarify it. What was the intent of the text if they're currently about modular approaches?

John Glaser – Partners HealthCare System – VP & CIO
I think the modular, which came out of the discussions … I think it's a terrific idea so that you can get multiple sources. And you have two acts of integration or interoperability. One is with the external world, which is the sort of focus of HITECH. The other is between modules within the setting. By and large, this stuff is avoided dealing with between modules within the setting partly because that wasn't sort of spelled out in the legislation, and partly because you could find yourself. You have to be careful about the slope you wind up forcing a retrofit of lots of little departmental systems within the walls of organizations, etc., and just making this already again, already very tight timetable. You know, it's just moving….

I think, if I'm listening to Paul correctly is that there ought to be some standards about between modules. They might be within the setting … between a module and the outside world, in which you could say, gees. That module ought to line up with this standard, or that module ought to line up with that standard, as presented in the IFR. So it ought to be able to address the external world interoperability. To the degree that it doesn't, and there's a standard missing or whatever, then we need to hear that because we will have left the industry without knowledge about what to do for a particular module and a particular type of exchange.

Paul Egerman – eScription – CEO
Yes. This is an interesting discussion. I mean, I was thinking about your example, Latanya. I would vary your example to try to illustrate my point is that you said you thought about modularity as it relates to your computer. The way I would think about modularity, as it relates to my computer, is like I could buy any disk drive I want and plug it in. I can buy any monitor I want and plug it in. I could buy any keyboard I want and plug it in. The benefit of that is, you know, you've got people who are best of breed. It's the best monitor or the best disk drive or something, and the purchaser has a lot of flexibility.

The intent of the modularity on the EHR system came partly from our discussions because we wanted to avoid a situation where all these systems had to be bought from a single vendor who produces a single, sort of monolithic system. We were afraid that that's – that there was – that that's not necessarily a bad thing, but that there might be an alternative, an alternate way of doing things.

Having said all of that wonderful stuff, perhaps the best way to handle this issue is to say, well, it's interesting, but it doesn't really directly relate to this IFR though. In other words, we can have other discussions about this and make recommendations about this when we get closer to stage two. I don't think we necessarily have to do this right now, as I listen to it, because I think you have some good comments, John. At what point do we get beyond the scope of what we're supposed to be doing?

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
This is Rick Chapman again. I think you're right. I think this is interesting, but I still think the spirit of the modular approach was to do just as you said. And as we maybe for a further discussion later, we could talk about this. But I think also there's the superset of meaningful use and the exchange rules, and that, in their entirety, are going to get us where we want to go, and that the primary purpose of the modular approach was just to make sure you didn't have to source all of the modules to be a part of your EHR from one vendor, and that they could all be certifiable.

M

Yes. I agree with what you're saying, Rick and Paul. I think this goes a little bit deeper than I think we even fully comprehend the challenges that would be associated with it. The best thing to do is to deter the discussion or the subject. This really shouldn't be part of our comments at the March meeting because we have other time to discuss this further if we want to.

Latanya Sweeney – Laboratory for International Data Privacy – Director
This is Latanya. I agree with that because I think John makes me think about even the discussion that we just had from the comments. It totally revamped what I was thinking of modular and what a module would be. Even that's, if we were to try to specify that now is a lot of pressure on manufacturers.

Paul Egerman – eScription – CEO
That's right. On my notes next to the Item D, I made a big X. That's how I attribute it, so we'll do that one later. The next topic is also an interesting one. It does get back to the comment that you made, Latanya, about multiple standards where, in the IRF, there's a number of places where it talked about various vocabulary nomenclature standards. And it would perhaps list one, but in some places it listed like two or three that might be future standards. And the observation that I made, which might be controversial, is I have sort of like a more limited view of these vocabulary standards, but I think that they're really important for the issue of exchanging information. So, for exchange, I think there needs to be one vocabulary standard.

But that only is what's in the vocabulary, the specification for the exchange. I don't think it necessarily has to be represented in the rest of the system. For example, if you said CPT-9 is your standard for diagnostic information, that's fine. That doesn't mean that what the physician sees on the screen has to be written in ICD-9. It could be SNOMED. It could be something else, or maybe RxNorm is a better example. Maybe RxNorm is what you use for e-prescribing because a physician, they have a universe of only 20 meds that he or she always prescribes, and they may never see any codes at all. It could all be invisible to them.

I don't know if what I said made any sense. Do you have any reaction to it, John? Hello?

Latanya Sweeney – Laboratory for International Data Privacy – Director
I don't know. John might be on mute or something. I was just going to say that this is really the tricky stuff. And, you know, I'm not sure where we, as a committee, want to come down on this or as a working group. But I think this is really the place where you're either going to make interoperability work or not. If you think about it as the World Wide Web, you can only have one version of HTML, and when it first came out, there was a lot of competition to have alternative versions that were manufacturer specific by slightly different changes. And if that had prevailed, we wouldn't enjoy a Web, the interoperability that it has now.

At the same time, I realize that things like proprietary stuff does get adopted naturally by the industry, but without the standards sort of being set originally, I don't think we're going to get there. So I think you're mechanism for saying that these standards were only in the exchange and not where you have to use it elsewhere sounds attractive. I mean, we have other people on the phone who can speak more to how onerous this whole thing can be.

Paul Egerman – eScription – CEO
Yes. It's certainly what Rick, and Larry, and Marc think about this.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
Okay. I'll be brave and jump in. It's Larry. So I guess a bunch of things. Partly, I can be a guy who likes

a lot of specificity around why I'm using a particular vocabulary. For example, the very broad area of diagnoses, we have CTP-9 transitioning to CPT-10, and we have SNOMED. And my sense from folks who I think know those coding schemes better than I do, so a little bit of this is second-hand is that SNOMED is intended to be a very granular description of individuals and what's happening with them. And ICD codes are meant for populations, and so they're intended to take a very granular description, and then code it into some kind of category.

So the thinking of those folks that I agree with, so again, it's sort of second hand, is that you would want the clinicians working in SNOMED and things that were intended to communicate a lot of granularity, you would have behind the scenes coding in SNOMED so it could move with semantic consistency between systems. But where you were trying to do, say, billing, and you wanted more broad based codes, or you were looking to do some level of population health reporting, and you needed broad based codes, you would map those into CPT-10, for example. And so that would be sort of where I think you were alluding to, Paul, that you could do that behind the scenes. But, depending on the use, you might in fact be transmitting both CPT-10 codes and SNOMED codes.

Paul Egerman – eScription – CEO
Right … my view is, that would be fine to do. I'm just saying, for each exchange, or for each data type, if that's the right expression, there'd be one that everybody would use. So CPT would be used for diagnostics and stuff because that's what you've got to do for billing anyway. So you'd always have to put the CPT-9 or 10 code in. You could put the SNOMED code in if you had it. But by doing that, everybody has got the same language for diagnostic codes, and then these systems would start to talk to each other.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I think that's actually a really good example of, I would say it really depends on the use. If this is supposed to be a problem list, we probably don't want to see ICD-9 or 10 as the primary code. We probably want SNOMED as the primary code.

Paul Egerman – eScription – CEO
Okay.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Paul, this is Rick Chapman. Maybe we should address this one like you addressed some of the other areas where there were multiple standards specified where we said we prefer to see more specificity. However, would like to understand the reason why there has to be more than one, something of that nature. I think we kind of agreed on that on some of the earlier discussions because unless we understand some of the reasons, like Larry was talking about for multiple standards and why they might be applicable, the whole purpose was trying to get down … one as we could.

Paul Egerman – eScription – CEO
Okay.

John Glaser – Partners HealthCare System – VP & CIO
Yes. This is John Glaser. I think that's fair game. I mean, there clearly were reasons that were deliberated within the federal government, and you can imagine the discussion with CMS about ICD-10. But I think it's game to say we'd like to have those reasons made public, and understand not only why … government, this is us. But also, what are your plans, if any, to narrow that, and maybe not on 2011, but certainly by 2013. I think that's … you could lump, as your point, several of these under one sort of broad request.

Paul Egerman – eScription – CEO
Okay.

M
A further clarification and discussion because, I mean, obviously it's a Holy Grail if we could get to a single vocabulary, but I think there are a whole lot of reasons why we haven't. I know the effort here even just taking the various vocabularies and trying to normalize those for use within our own systems is a huge effort. So my guess is that we'll do a lot of discovery through this process, and it would be good to hear what they have to say.

Latanya Sweeney – Laboratory for International Data Privacy – Director
What about an out-of-bound solution going the other way? So to what extent can we allow, not to put the stake in the ground on one, but make public services that translate across them like the UMLS or even something more specific even than UMLS. But, I mean, if you had a public service, then you could just give you one. It gives you the other one back, so at least the translations were common. Then it wouldn't matter so much what you used to store.

M
That'd be awesome.

Latanya Sweeney – Laboratory for International Data Privacy – Director
I mean, that is the goal of the UMLS. I don't know what state it's in.

John Glaser – Partners HealthCare System – VP & CIO
Yes. I think, Latanya, what we're going to see is … open source and proprietary offerings to do exactly this kind of crosswalk so that people will may be forced to use both for a period of time … ease that challenge. I suspect we'll see … along those lines.

Latanya Sweeney – Laboratory for International Data Privacy – Director
That would ease a lot of the tension of trying to push down to one standard because if you had the ability to just, an open source, easy service module that … off the Web, that would be very convenient and allow the systems to do and use whichever the standards they wanted to, and take pressure off the manufacturers of what they're feeling right now that they have to do everything.

John Glaser – Partners HealthCare System – VP & CIO
I think one of the things you might suggest, and maybe give the industry a little bit more time, but to revisit this conversation summer/fall and say, are there – the industry figure out ways to make this trivial, so that a single one is really not that much of an issue, or it's better, but it still isn't good. And so one really should remain the goal here because even these translators are not perfect, and somebody is doing something to affect the translation and dealing with imperfections that come along the way. It's costing the organization something. But it may be that there's a little bit more time … how much of burden this stuff really is.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Yes. And also, in the example that was given, some of these translations are one way: SNOMED to ICD-9, but it can't go back.

Paul Egerman – eScription – CEO

Well, yes, that's right because you can translate something that's general to something that's – from something that's specific to something that's general, but it's hard to go the other way around, and so sometimes you can only go one way. Your comment is a really good one, Latanya. I'm trying to figure out how we capture that thought in what we want to say about this. If I hear what Rick said correctly, it was, we should handle this the same way we handle the other things, which is, we'd prefer to have a single vocabulary standard, and in these places where there's more than one, we would like an explanation as to why more than one is being proposed, and whether or not there's a map or a direction for a single one. Should we say and also whether or not there exists translation services?

Latanya Sweeney – Laboratory for International Data Privacy – Director
Right, either there exists a cross map or a translation service or plans for such a service to be made available.

Paul Egerman – eScription – CEO
Okay.

M
Yes, and I think we'll find that both, there are some services right now, as John mentioned, and some of the vendors are really trajectoring, or that's not even a word, but headed towards those types of solutions.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Yes. This is Rick. Maybe by posing the question that way, Paul, we can get the people, I'm sure, who have done a ton of work on this to at least give us their rationale and maybe even the pathway they may have already defined to eventually get to one.

Paul Egerman – eScription – CEO
Yes. Let me ask the question about the process here, John, if you could help me with this, or if somebody from ONC can help me. I mean, are these questions that we should just be asking at like the policy committee, or is this something that we can just call up somebody and say, hey, can you explain this to us?

John Glaser – Partners HealthCare System – VP & CIO
I think, Paul, you ought to let the committee know that these are the questions to be pursued. And it doesn't preclude you reaching out to do that along the way, so I think you'd do a little in parallel. But I would certainly let the committee know the essence of this discussion and the things that you think need to be pursued. I don't think you have to wait for full permission from them to start asking some of these questions, but I would certainly do the public part of it.

Paul Egerman – eScription – CEO
Okay. That's helpful. If everyone is okay, I could have a sense of where we want to go with this, and I'll write up a summary. If everyone is okay, I want to move on to the next issue because I want to be mindful of the time. The next issue I had on my e-mail was this issue of the certification process NPRM. So this is the issue that you and I, Rick, talked about earlier where the NPRM has not yet been issued that describes the actual certification process. As a result, there's some amount of anxiety among vendors who are worried. How do we know how this is all going to work, or when it is all going to get done?

When we had done our recommendations in August, we said, in that interim period until you had a new certification and process, process in place, that they should use some certifications that are done by CCHIT, provided that they correspond with whatever is in the IFR. And what I was thinking is that maybe

we should just repeat that. But I personally think that if David Blumenthal would like to say that out loud, he would eliminate a lot of anxiety that exists about how this whole thing is going to work.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
Paul, this is Rick again. I certainly agree with that. And I would just like to add, I think our intent, and maybe we should just state it, is that if in fact, to the people who will be applying for this funds, is if you select a certified system, it has been our work and through the definition of functionality when added to your people and process would allow you to get and achieve meaningful use. And so what we can't have is any difference in the definition between the two rules. I think we just said the same thing, but I just wanted to make sure I said that.

Paul Egerman – eScription – CEO
Okay. Any other comments about this?

John Glaser – Partners HealthCare System – VP & CIO
Just some background stuff here, I think there was clearly, based on your all recommendation, a pursuit of could you quickly, and this was back in the fall, just to point a group to do interim certification, etc., whether it was CCHIT or anybody else. And the lawyers, the … operating on very thin legal ground there, and you could get sued, which would … this thing up for years to come. So I think that was really looked at, and there was no good legal basis to go off and do that that was effective, moving this agenda forward, so just to be aware of that.

The second is that the NPRM is due out soon on the certification process, which will mean that either because it's imminent or because it's out by the time we get in front of the full committee, David will be really, really limited on what he can say or even signal during the course of that. So it shouldn't hold you up for making recommendations you want to make. Just be prepared that he may not be able to say anything. And also just to understand, and I'm not sure that anybody is happy about this, but there was not sufficient legal ground … LOINC….

Paul Egerman – eScription – CEO
Well, there may not be sufficient ground to appoint someone, but maybe there's a way to do it another way, which is, instead of appointing them, it's to accept it in the interim to say, if anybody has shown this level of testing, we're going to accept it.

John Glaser – Partners HealthCare System – VP & CIO
Yes. Unfortunately, that'll be part of a process, the NPRM process, and so he won't be able to signal yeah, neigh, or indifferent on that.

Paul Egerman – eScription – CEO
Yes. So if I'm hearing this right, we can make whatever recommendations we want, on one hand. One the other hand, he can't accept this recommendation, which in that case is not really worth making, right? In other words, if we're telling him we want him to do something he can't do by law, that's not really a good use of time. I mean, what I interpret your comment to mean, John, is we should not make this recommendation. Is that right, or is that not right?

John Glaser – Partners HealthCare System – VP & CIO
No, I think you can, Paul. You just have to be prepared for his comment that he may not be able to do anything about it right now or may not be able to say anything. You're right. If you have 20 minutes in front of the group, you don't want to spend 10 minutes on this if you know that the outcome is he just can't

say anything. But on the other hand, I wouldn't let that cause you guys to not lift it or to not comment on it. I just wouldn't spend an amazing amount of time on it because … are pretty narrow here.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
This is Rick again. Maybe we should just make – we first should decide if we should make any comment, Paul, based on this discussion. But, second, maybe we ought to think about making a comment that said due to the – since we're making comments, maybe we want to speak to the point that since the NPRM has not been issued yet, that we want a reconciliation between the recommendation for certification between the two to make sure they're consistent, or something to that point. I think all we're really trying to make sure is that they're consistent and then if we can kind of get that dependence, it's something maybe the vendors can hang their hat on that what we've basically recommended for certification is going to happen. I don't know what you think.

Marc Probst – Intermountain Healthcare – CIO
Rick, this is Marc. I don't know that we're going to get that answer, based on what John just said. I do think there's some value, though, in expressing the fact that we're hearing what the vendors have to say that, you know, the fact that there's still uncertainty out there is creating this anxiety. But if ONC can't answer the question that's posed here, you know, we may just restate. We think this an important approach, and we'll be looking forward to the NPRM.

John Glaser – Partners HealthCare System – VP & CIO
Yes. And hopeful ONC moves through the process as rapidly as it possibly can.

Marc Probst – Intermountain Healthcare – CIO
Yes.

John Glaser – Partners HealthCare System – VP & CIO
The closer on the rule, but also standing up whatever the rule finally agreed to … get done.

M
Can I just ask a quick question? I remember when we were talking earlier at the first hearing, the hearing that I attended anyway. There was some discussion about hospitals, for example, that had legacy systems, and whether or not those systems needed to be certified. If I'm understanding what you guys are saying now, basically we wouldn't be certifying or there won't be certification of hospitals. It would only be – even if they had a legacy system, it's certification of the system itself. Is that correct?

Paul Egerman – eScription – CEO
This is Paul. Let me try to clarify. What gets certify is the software, is the system.

M
Okay.

Paul Egerman – eScription – CEO
The extent that we were talking about individual hospitals needed to be certified is really for people who had self-developed systems.

M
Right, but it's still the system itself that gets certified.

Paul Egerman – eScription – CEO

It's still the system itself getting certified, although there was some complexity there. But even that whole discussion about how self-developed is going to get certified, how open source is going to get certified, how vendors are going to get certified. That's like the missing piece right now, the missing link that we're waiting to hear on the NPRM. That's why there's some anxiety. People don't know that.

To summarize what I heard is, when we do our discussions on this, we're just going to say there's a lot of anxiety, and we need to get that clarified as soon as we can. But that, you know, for example … we had 20 minutes to talk … spent no more than 20 seconds on it, even though there is anxiety on it because there's probably not much David can be doing. What I'm hopeful is, between now and the 17th, the NPRM actually gets issued that could answer a lot of questions. I think I know what to do on that.

In going through the agenda, I had another thing in my e-mail, but actually rather than do that, I keep looking at the time. I want to make sure we hit Joe's issue. You had an adoption issue that you wanted to raise, Joe.

Joseph Heyman – AMA – Bord Chairman

Well, let me just, if you guys don't mind putting up with about four minutes of stuff, I'll give you an example of what I'm concerned about. Let's leave the CPOE part of this out of it for a moment. For example, the requirements are e-prescribing for permissible prescriptions, 75% reporting threshold. In order for me to do that, and I have a solo practice with a single employee, I would have to count up all my paper prescriptions, even though the only ones I actually write are for narcotics. And then I would have to somehow have a list of all the ones that I e-prescribed, which I don't have any software that can do that, that can actually count them. It can show me what I've done, but it can't count them. Then I would have to divide the numerator by the denominator.

I think those kinds of requirements are just not doable by solo practices or small practices without hiring people to do that. For a practice like mine, which has been doing almost all of the requirements since they were available, I've been doing this since 2001, I would not participate. Maintain an up-to-date problem list for at least 80% of all unique patients. I maintain a problem list for all the patients that have problems, but I have no way of establishing that it's 80%. Maintain an active medication list for 80% of patients. I do that for every patient. But I have no way of establishing that it's 80%.

Maintain an active allergy list for 80% of all unique patients. Here again, I do it for 100% of my patients, and it's all electronic. But I have no way of measuring how many patients have it and how many don't. Record the demographics for 80% of all unique patients. I have to record demographics on every patient, but I have no way of knowing which ones have it and which ones don't.

Record smoking status for patients 13 years and older for 80% of patients. I record that on every patient, but I have no way to figure out how many patients I've recorded it on. Record and chart vitals for 80% of all unique patients, I do that at every annual exam. I have no way of establishing how many have the vitals and how many don't unless I hire somebody to do that.

Now my concern, I'm not going to go through the whole list, but my concern about this is that the large entities like Partners and Cleveland Clinic and Mayo and Kaiser, they can do that without any problem. They can probably do all of these things without any problem. But they would be participating in all of this stuff, even if there were no ARRA. But for the small practices, asking people to count things and define numerators and denominators, it's not going to work.

Latanya Sweeney – Laboratory for International Data Privacy – Director

This is Latanya. I have a question for you or a consideration. But if you were buying a new system, isn't this a feature you would expect the vendor to provide…?

Paul Egerman – eScription – CEO
But there's no way the vendor can provide it because if you're going to say you're going to record it for 80% of the patients, for example, how does it know how many patients it's not…?

Latanya Sweeney – Laboratory for International Data Privacy – Director
No, but he needs to count – granted, those that aren't in the system, he can't attribute to. But those that are in the system, it should be able to give counts, right?

Paul Egerman – eScription – CEO
Yes, it should be able to give some counts of what's in the system.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Right.

Paul Egerman – eScription – CEO
The problem is that it doesn't know what's not in the system.

Latanya Sweeney – Laboratory for International Data Privacy – Director
But many of his examples were easier to solve.

Joseph Heyman – AMA – Bord Chairman
How about submitting claims electronically for 80% of all claims filed.

Paul Egerman – eScription – CEO
Right.

Joseph Heyman – AMA – Bord Chairman
Some claims require evidence, so you have to do those on paper. Now if my system could count up how many times it printed a claim, as opposed to how many times it submitted it electronically, I suppose it could do that. The only thing is that sometimes I have to submit the same claim three times, and sometimes the same claim will be electronic twice and paper once.

Paul Egerman – eScription – CEO
Right. The basic thing that I hear you saying, Joe, is you have this concern about these, you call it, reporting rules or these metrics, and that also you view them as an adoption hurdle or adoption barrier because you think it's much harder for small physicians or solo practice than it would be for, say, Intermountain Healthcare or Kindred Health.

Joseph Heyman – AMA – Bord Chairman
Right. Me, personally, I'm already doing all this stuff, and I would not participate because I don't have the time or the energy to make all these counting things. If somebody else did the counting, if my software did the counting, that would be okay. But I've already got the software.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Yes, but we're not reimbursing you for your software. We're reimbursing you for the software that's going to be certified, right?

Joseph Heyman – AMA – Bord Chairman
No, you're reimbursing me for meaningful use, for participating and doing this in a meaningful way.

Latanya Sweeney – Laboratory for International Data Privacy – Director
You had to buy a new system, no?

Joseph Heyman – AMA – Bord Chairman
I already have a system. I've had it since 2001.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Right, but we're not going to reimburse you for that system.

Joseph Heyman – AMA – Bord Chairman
But you're supposed to.

M
Yes, we will.

Joseph Heyman – AMA – Bord Chairman
I'm using it for meaningful use.

Paul Egerman – eScription – CEO
Let's go back to basics. Technically, Joe would get Medicare or possibly Medicaid sort of payments or adders because he's using a system that is certified, and he's doing meaningful use … all those things.

Joseph Heyman – AMA – Bord Chairman
That's right.

Paul Egerman – eScription – CEO
Now whether or not he has to buy a new system, or if he's lucky enough to have already purchased one that's certified, that's irrelevant. He has to have both those things in place. So the basic issue is you have this concern, Joe, and what we need to understand though is, you know, how do other people view this and what should we be recommending as a result. In other words, we can't just say we have a problem. We ought to be saying, here's what the solution is.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
It's Larry. Let me jump in with a thought about splitting this into at least two parts. On the one hand, I think there are, as Latanya was saying, there are some things that the software could do to count it. And hopefully this is not a buy a whole new application. This is a minor upgrade from a vendor that allows it to generate the counts because it has the capability of providing you the lists, as you said, so … summary count, and that's sort of the value add that the big providers have done for themselves over the years. They've created reporting suites to create statistics.

But your other point is that some of the statistics that you're asked to report on require a lot of manual work because the electronic system only knows what it's doing. It doesn't know what's not electronic. That's true also. So I think we should comment on that second piece because that does create a big burden of how do you do the counting of the things that are on paper, and perhaps some recommendations, if we go through some of the details, of alternate measures or alternate ways to phrase the measure so that you don't have to capture what's on paper. But you still get a valid count.

Joseph Heyman – AMA – Bord Chairman
That was going to be – my recommendation was going to be, instead of asking for percentages, ask for absolute numbers. That would be on way in which you can do this without it creating as much of a burden.

John Glaser – Partners HealthCare System – VP & CIO
I think this is a legit concern, and not only for small practices, but, frankly, Partners … how many people would we need running around doing this stuff, so I think it's a fair concern about whether, either you don't know … or the system is unaware of the denominator, or even the certified system doesn't calculate this stuff. So you could be ... certification criteria. It's a meaningful use criteria, so you could have a perfectly certified system that is not capable of doing this stuff easily.

One is that this is a meaningful use comment, not an IFR comment. The second is that it's legit, regardless of size of the organization. When voiced by multiple folks, I think it's worth putting on the table, and I think it's worth saying we need some guidance from CMS about how to do this in a way that doesn't cause these practices to either incur extraordinary unnecessary costs, or be faced with the prospect of turning away Medicare and Medicaid patients. If there are simple ways to do this, or either we know the numerator, but we don't know the denominator, or the system is unable to calculate the ratio, what would you suggest that we do?

Joseph Heyman – AMA – Bord Chairman
John and Latanya, just to go back to the adoption issue, my concern is it's not a problem for me. I do this stuff already, and I didn't do it in order to get the reimbursement. But if the idea of the reimbursement is as an incentive to get people to adopt, and then you have rules that scare them away from participating, that's going to be the problem.

Paul Egerman – eScription – CEO
That makes sense. Also picking up on what you're saying, Joe, and what you just said, John, maybe we should be adding certification criteria that counts what I call the numerator. And the things where it says you've got to 80% of your e-prescribing, it gives you the data so at least you know what's the number that you did.

Joseph Heyman – AMA – Bord Chairman
It has to count both the numerator and the denominator.

Paul Egerman – eScription – CEO
I know, but it can't count the denominator because it can't count what it doesn't have in the system.

John Glaser – Partners HealthCare System – VP & CIO
I think it's … Paul, to come up with or work on some criteria that deal with, in cases where it's relevant, to Marc's point, where you can do the numerator and denominator. You say, listen. I've got this many people with scheduled appointments who showed up in this calendar year, so I know the denominator. Now I'm looking for the numerator of a non-zero or non-nul problem entry here. And so that, given some guidance from CMS about … how to do this, these could become pricier. I think, in other cases, if the system is not aware of the denominator, how many prescriptions you actually wrote on a pad. You know, it may not be a relevant certification criteria, but nonetheless, the group could take a look at where it would be relevant, and it could become a criteria versus where we still need alternative ways to help people like Joe do this.

Paul Egerman – eScription – CEO

Right. I'm trying to understand what you just said. Let's look at something like the e-prescribing thing that said something like 80% has to be done electronically, if I heard it right. One way you could implement that would be to say, well, the system has to tell you over specific time periods how many prescriptions you entered electronically.

John Glaser – Partners HealthCare System – VP & CIO
Right.

Paul Egerman – eScription – CEO
That's not the entire answer. It's half the answer because you need to know what were the ones that you didn't enter electronically. But it would have to tell you that number.

Joseph Heyman – AMA – Bord Chairman
Here's the thing with that, okay? I get this thing from BlueCross BlueShield every year that tells me that I'm either in or an outlier on the number of e-prescriptions I write, so they're getting that information from someplace completely different than me. I don't, I mean, if you can get that information anyway, why are we knocking ourselves out trying to get it from the docs?

Paul Egerman – eScription – CEO
I understand that, but what I'm trying to do is try not to knock out the docs in doing this. Part of what I'm hearing is the vendors are probably going to do some or most of this anyway, but maybe we need to have certification criteria that says where counts are needed for the reporting rules, the system produces it.

Joseph Heyman – AMA – Bord Chairman
I would love that, but it has to produce….

Paul Egerman – eScription – CEO
It's not 100%, yet, but I'm going to get to the 100%, but that's like the first step, and so my question there is, if we made that as a comment, can we make it that general, or do we have to go through the NPRM and say we want it to count e-prescribing. We want it to count the number of times you do vital signs. Should we go through each of the things and specifically list it out, or can we just say we want it to count up the numerator when metrics are possible.

John Glaser – Partners HealthCare System – VP & CIO
Paul, you could do it in two stages. One is you could say for 2011, we need some guidance from CMS about how to do this in a quick and dirty, easy fashion that doesn't require a lot of staff. We're open to ideas about how to do that. Maybe to even sort of put your thumb in the wind and see whether it feels right.

The second is, well, in giving the vendors time to deal with the software, we're going to work on some criteria for 2013 that really capture, based on the 11 measures, and as we learned about the 13 measures, where these really should be certification criteria, both the numerator and the denominator, or in some cases just the numerator.

Paul Egerman – eScription – CEO
Right. The reason I ask it is, in the policy committee meeting, what I thought I heard was the ONC people is they wanted us to make our comments very specific. They wanted us to just say here's a problem. They wanted us to say, here's the problem, and here's what we want you to do to solve it. And so I especially heard that as it related to the IFR where they said, well, this is 99% done. You've got to be very specific if you want us to make any changes. Maybe I heard it wrong, but that's what I heard.

Joseph Heyman – AMA – Bord Chairman
I've got a list of 17 things, starting with CPOE, which require somebody to do something on paper.

Paul Egerman – eScription – CEO
Let's do this. Why don't you e-mail me the 17 things?

Joseph Heyman – AMA – Bord Chairman
Okay.

Paul Egerman – eScription – CEO
Is there agreement that we want to make a comment or recommendation that there'll be certification criteria that at least counts the part that's done within the computer so that you can assist providers in doing the reporting.

Rick Chapman – Kindred Healthcare – Chief Administrative Officer/CIO/EVP
This is Rick. I think yes is the answer, and even the two parts John talked about, and we want to have some way to address the stuff that's required outside the scope….

Paul Egerman – eScription – CEO
Yes. And the part that's required outside, what I would do is pick up on what John Glaser is saying is saying is suggest that we would ask for some, either clarification or guidance that says how are you supposed to do this. Are you really supposed to count at all? Can you do an estimate? Can you do a statistical sampling? In other words, look at one percent of your patients and count them. Is there a way that HHS can give us guidance so that this is not onerous and labor intensive?

Latanya Sweeney – Laboratory for International Data Privacy – Director
That sounds good, making sure that the second point is clearly on the adoption issue.

Paul Egerman – eScription – CEO
Yes. Who just spoke?

Latanya Sweeney – Laboratory for International Data Privacy – Director
That was Latanya.

Paul Egerman – eScription – CEO
Yes. Again, it's really … this is not where one would expect there to be an adoption problem. In other words, we thought adoption would be that nobody wants to do CPOE or something. But it's certainly a legitimate one. It's sort of like it's too hard to apply for the thing.

Joseph Heyman – AMA – Bord Chairman
Exactly.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Yes. This is also Latanya. I just want to say one thing about why you can't just do the numerator. I know that came up. That has to do with competition issues and things like that. There's a lot of pushback on just numerators.

Paul Egerman – eScription – CEO

Right. I agree. You can't do the numerator. But you also have to do the numerator. You have to be able to do both.

Joseph Heyman – AMA – Bord Chairman
What I'm suggesting to you is that the idea of this is to cause people to adopt this technology and use it in a meaningful way. There are measures that you could do that would require just counting. I mean, there are plenty of things that we do counting on. I just, I think it's, you're never going to get a small practice to do this.

Paul Egerman – eScription – CEO
Yes.

Joseph Heyman – AMA – Bord Chairman
And that's what we were aiming this at. I mean, 60% of us are in small practices.

Marc Probst – Intermountain Healthcare – CIO
Paul, this is Marc. One approach is to certainly certify that the system can do certain things. It's also fair for us to ask CMS to readdress what they're asking for reporting wise, and I think that's maybe what Joe is getting to in just doing the counting part versus some percentage. And that CMS really needs to help us or help understand that adoption is difficult in some of the things they're asking for us to do, and they may want to reconsider how reporting is done.

Paul Egerman – eScription – CEO
It's another recommendation … stage two that all the metrics should be generated by the system.

Joseph Heyman – AMA – Bord Chairman
That's, I would 100% propose that that be a requirement for both the systems and for CMS … they get together and figure it out.

Marc Probst – Intermountain Healthcare – CIO
Figure it out. Amen.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect
I wanted to, Paul, just break in for a second. It's Larry. I want to pick up on something else Joe said, which is that there may be other ways to get better information than having the docs self-report. And so his example of BlueCross BlueShield says here's a summary of what you e-prescribe, and they know that because they get the bill from the pharmacy, and the pharmacy tells them this was an electronic prescription. This was a manual prescription.

Paul Egerman – eScription – CEO
Yes. That makes sense. Or even look at that example is they get the information from BlueCross. Or maybe they get the information from the pharmacy itself. Maybe they're across the street from a Walgreen's or something or CVS, and CVS tells them, you know, here's your statistics. It would certainly be another way, but it's really other sources.

Joseph Heyman – AMA – Bord Chairman
Of course, there are a lot of pharmacies, especially in some of the rural areas, where you can e-prescribe, but they don't receive an e-prescription. They get a fax.

Paul Egerman – eScription – CEO

There are lots of examples of other sources. I mean, the other sources could be the payers. Maybe the payers can tell you that, gee, you're 100% compliant with the electronic claims submission, or you're 90% compliant … if they could tell you. It's a very interesting thing here. You raise a lot of good points, Joe, because first we want to make sure that the application process isn't by itself pushing people away.

The other interesting point is there was a fear of doing self-attestation, which was a fear that people wouldn't tell the true. You're surveying this from the other side. There's a fear that people will be so focused on telling the truth, they won't be able to fill out the form because they won't know the right answer.

Joseph Heyman – AMA – Bord Chairman
Right. I mean, I could tell you that I e-prescribe probably 98% of the time. But if I have to be able to prove it in an audit, all I can prove are the ones I e-prescribed. I can't prove the others.

M
At the risk of getting into way too much detail on this one particular thing, I'm sorry, I can't help myself, so bear with me for a second. If we look at the requirement to maintain an active med list, that's really separate from the prescriptions part, and so I wonder if in fact we don't have a linked set of counts here that you could say, of the patients who have a med list, how many of those meds were issued by the doc electronically and how many weren't.

Latanya Sweeney – Laboratory for International Data Privacy – Director
…somebody else may have wrote the prescription.

Joseph Heyman – AMA – Bord Chairman
Right. My med lists consist mostly of other people's prescriptions.

M
Good point.

Joseph Heyman – AMA – Bord Chairman
And my software won't tell me how many patients have a med list.

M
So we're back to, you need it to give you counts if you're going to be responsible.

Paul Egerman – eScription – CEO
Yes, but see that part I think we can fix. That's a very reasonable thing because it should fill out the form for you or at least parts of the form for you, so you should be able to do that part for you.

Joseph Heyman – AMA – Bord Chairman
But it can't do it now. It's got be ready by 2011.

Paul Egerman – eScription – CEO
I know. Well, I've got some ideas on this.

Joseph Heyman – AMA – Bord Chairman
Who was I supposed to e-mail it to? I e-mailed it to Paul. I don't know who else I'm supposed to e-mail it to.

Paul Egerman – eScription – CEO
That's good. If you want, you can e-mail to everybody.

Latanya Sweeney – Laboratory for International Data Privacy – Director
Yes, this is Latanya. I wouldn't mind looking at it to see if I could find some ways to combine them.

Joseph Heyman – AMA – Bord Chairman
Okay. I'm going to send it to everybody.

M
Thank you.

Paul Egerman – eScription – CEO
In a minute, what I want to do is I want to turn to our patient safety discussion, but what I'm going to do with all this because, unfortunately, we're on, as usual, a tight timeframe. Tomorrow morning, Marc and I have a phone conversation with a number of the other workgroup cochairs, and we'll review with David Blumenthal what our comments and recommendations are in advance of the meeting on the 17th. And so, on the 17th, we're supposed to be presenting.

What I'll be doing is trying my best to write this thing up tonight and tomorrow morning, and I suspect whatever I write up, in terms of like an e-mail to summarize this whole discussion, I'm not going to quite capture it correctly. What I'm going to ask you all to do is to go through it all and tell me what's right and what's wrong, unfortunately, in the next couple of days, so that hopefully we can get this correct in front of the group. That's what I'm going to do.

So I'm going to try to write this up with the combination of certification criteria for the stuff that's countable and guidance for how to do the counting for the manual processes, and also to make the observations, the acceptability of using other sources, other sources being information from insurance companies and pharmacies and whatever else sources, you know, possibly hospitals or referring physicians. There might be a whole series of sources that you could use.

Before we go on to patient safety, are there other things on certification or adoption that people want to discuss? I will interpret the silence to mean no. And, Marc, why don't you talk about the patient safety?

Marc Probst – Intermountain Healthcare – CIO
Thanks Paul. Why don't I just do kind of a quick dump of information? A lot of this you've gotten. You should have received the agenda, and I'll go through that briefly. Then, at the end, just any comments or thoughts you have about the process or where we're headed.

We've been asked by ONC, as the adoption and certification workgroup, to look at patient safety issues related to the use of EHRs and both at the risks of their use and then any approaches that individuals might have relative to mitigating those risks. I'm not sure what raised this up to the top of the thought process right now. I know Senator Grassley put out a letter recently, a questionnaire to several organizations. We received it, and it did have to do with HIT and some of the risks associated with it, and how vendors are handling those risks.

Anyway, on the 25th, working with ONC, and they've done a great job, by the way, pulling a group together in a very short period of time. We've been asked to meet in Washington from 9:00 to 3:00 to go through this hearing relative to patient safety and the risks associated with it. Working with the

leadership, we've put together a group of panels, three panels, and really broke it into three areas or themes.

The first one being identifying the issues associated with it, so what are some of the patient safety risks, and are there any that are introduced just simply because of EHRs or even risks that inadvertently occur because of the use of electronic health records or some of the other HIT products. What are some of the specific kind of risks that are there? What kind of causes are there for those risks? What do people know? What might we do to prevent those risks or mitigate them?

And a lot of this conversation initially has been around the risk or some of the risks associated with decision support and the electronic health records. What are some of the benefits of EHRs, and how does that benefit counterbalance the risks that are occurring with patient care? How might the risks be best identified, as more HIT adoption occurs? Are we going to see greater risks because there's more digitized data or more broad use of EHRs? And then get into some of the issues around reporting. It's one of these issues that there is, in some organizations, a real fear to report an adverse event, and how might EHRs impact that or what might be done to help mitigate some of the problems of … reporting and make it a safer environment.

For that panel, we have four planned speakers or panelists, and I think you have those on the agenda that are there. Brent James from right here at Intermountain Healthcare, has not yet told us whether he would be there. Any questions, I guess, rather than me going through all of them right now, I'll go through that first one, and any questions about what we're doing, or do you want me just to complete going through what we're going to do? I'm hearing silence.

Latanya Sweeney – Laboratory for International Data Privacy – Director
For me, Latanya, I'm happy to go forward, but I'm just one vote.

Marc Probst – Intermountain Healthcare – CIO
Well, why don't I go through the rest of it, and then if there are any questions at the end, we can go through it? And this is something new. This is something brand new we've been asked to look at. I think it's a great area. I'm really glad we've been asked to look at this area. It's something I personally have a lot of interest in.

But anyway, the second panel is going to be around stakeholders really looking at experience, so individuals with experience in using EHRs and what they've incurred relative to patient safety risks. You know, what has been identified as specific patient safety risks, what kind of steps, what kind of either technologies or processes have been put in place to help prevent those risks or those incidences. How might we – what kind of things could we recommend to help prevent or put in place again for mitigating harm with EHRs. And what are some of the benefits and concerns about making these risks publicly known, which, well, I mean, that's obviously then what we're going to be asking the stakeholders.

The third panel and the last panel, and we have, what, six individuals, some vendors, some users, whether that's nursing users or physician users, that are part of that specific panel. There are six people on that panel that have been requested to be part of that. Then the third panel are just some possible approaches, so what kind of approaches would be recommended or would they recommend the policy makers in the industry consider to address patient safety issues. Now we're getting to the point where we're going to have to put recommendations to take back to ONC relative to these patient safety risks, what they are, and how to move forward.

We've really got government representation. We're looking at research issues, and some of the safety issues around research. And then an industry perspective overall of what's going on in the EHR area, and what are some of the safety and patient safety issues associated with that. I think we have a pretty diverse group of individuals. In that panel, there are four, everything from the government, Giesinger, AMIA, so medical informatics, focusing on that. Those are the three areas that currently we have – well, and I don't think we have time to change the agenda, so that's what the agenda looks like. I think it's a good agenda, and I think it's an interesting topic.

I suppose the question is what kind of thoughts just initially does this group have relative to our task of looking at patient safety, and just starting to pull together questions, whether in your mind, or whether we want to share that via e-mail, as we prepare for the 25th. And I think the last thing is, we'd have three panels. Paul and I discussed that it would be nice to have some of the workgroup be the moderators for each of those panels, and if any of you have a specific passion to help moderate one of those panels, just let me know, and Paul and I will discuss that, and we'll look at the assignments relative to doing that.

Judy Sparrow – Office of the National Coordinator – Executive Director
Marc, this is Judy. Just let me remind you all that following the 3:00 adjournment of this public hearing, you will go into administrative session for an hour or so.

Marc Probst – Intermountain Healthcare – CIO
And that's really to get those recommendations while they're fresh in our heads. Thanks, Judy.

Paul Egerman – eScription – CEO
No. It's actually just to have a discussion with HSS and ONC to make sure we understand the environment by which we can make recommendations, so if we can make recommendations more than just certification, like how do we relate to FDA. They're just going to explain a lot of the things because that's why we're doing it. It's like one hour staying after school. Did I say that right, Judy?

Judy Sparrow – Office of the National Coordinator – Executive Director
That's right.

Paul Egerman – eScription – CEO
Okay. So that's not on the formal agenda, but I would imagine that would take us from like 3:30 to 4:30 would be my guess. Is that a good guess?

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes, that's correct.

Marc Probst – Intermountain Healthcare – CIO
And we should be getting written statements from the panelists prior to this, right, Judy, so that we can…?

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes. I've asked them all to have them to me no later than the 18th. So what I'll do is distribute them not only to the workgroup members, but also to the other panelists. I can't remember if I sent out the questions that we asked the panelists, which I'll do first thing in the morning once I get this agenda finalized to the workgroup members.

Marc Probst – Intermountain Healthcare – CIO

Again, we really haven't gathered any information on that, but I think it's great that we've been asked to look at that. Clearly, as it relates to adoption, I think it's relevant to what our committee is working on. Anyone have any questions or comments relative to this task?

Latanya Sweeney – Laboratory for International Data Privacy – Director
Marc, this is Latanya. I have no qualms at all about jumping in. First of all, I think it's a great topic. Again, many, a lot of positive praise to ONC for bringing this forward, and I think this is a great group to look at this problem.

The one thing I do worry about is I'm not sure I understand completely the scope because when you started talking about patient safety, my mind goes from medication reconciliation, to medical identity fraud, to privacy breaches, to wrong or missing information, to conflicts caused by wireless devices in the setting, to the design of the NHIN itself to where it could create safety problems. And so I wasn't, I mean, I got a sense as you were talking that we're not sure either where all that is going to land. But it is a wide and rich area for discussion.

Marc Probst – Intermountain Healthcare – CIO
Yes, I think you're right on. Having that first panel being really identifying the issues that are out there would suggest we need to get our handle around what the whole universe is of issues that are here, and then start prioritizing and focusing on them. I think that's a great point, Latanya.

John Glaser – Partners HealthCare System – VP & CIO
This is John Glaser. I think you guys ought to cover a wide range and have the conversation take you where it goes. A bit of the sort of genesis of this, a researcher at Penn, Ross Koppel, has been writing recently about to what degree is EHR software safe. In other words, it's sort of well tested or the algorithms behave as they should, and there have been examples over the years where people have been hurt by faulty software.

In addition, and some of his articles in the *Annals of Internal Medicine* where there can be, you know, his claim, vendor practices that if John Glaser's organization discovered a fault, that you could have a vendor contract that precludes you from raising your voice about that. I think the centerpiece of the EHR itself and the immediate sort of circle of practices or other things that surround it and whether those are safe. The FDA's sense of a safe drug or a safe car, and that doesn't preclude, Latanya, your sort of broad range. But Ross Koppel's articles have obviously drawn the attention of Senator Grassley. And Ross makes some legitimate points, and so that's what Grassley is sort of interested in is, again, centered on the EHR itself.

Adam Clark – Lance Armstrong Foundation – Director for Health Policy
Marc, this is Adam. I just wanted to highlight, I've already alerted a lot of the cancer organizations that this is going to be going on, and there's a lot of interest in the advocacy community about health IT. They're much further back on the learning curve, but they do want to learn more, and particularly as it relates to their constituent safety. So I would encourage, if there are mechanisms for HHS through its Office of Advocacy … or other mechanisms to at least get this out to the patient advocacy community, that it's going to be going on. There may be some groups that are particularly interested. Of course, I'm happy to help where I can.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you. This is Judy. We will be sending out a notice about this on our 23,000-person listserv, so it'll be well publicized.

Marc Probst – Intermountain Healthcare – CIO
Great. Thanks, Adam. Yes. I'm obviously already getting some input. There is a lot of interest in this particular area. Any other thoughts, comments? I know we'll have a lot at 3:00 on the 25th.

Latanya Sweeney – Laboratory for International Data Privacy – Director
This is a huge area. My brain is like going crazy here. I mean, just even in the … is huge. I mean, this is really interesting.

M
Yes, I think this is going to be fascinating.

Paul Egerman – eScription – CEO
Yes. This is Paul. I agree. This is really an exciting thing to work on, and it's a great opportunity to really dive into some interesting issues. The question I have is, Joe, are you able to make it for the hearings on the 25th?

Joseph Heyman – AMA – Bord Chairman
Actually, I am. But you know what? I'm sitting here looking for Judy's original e-mail because I thought we were going to get out of there at 3:00.

Judy Sparrow – Office of the National Coordinator – Executive Director
I know. The administrative part of the meeting is not on the public agenda, which I sent you.

Joseph Heyman – AMA – Bord Chairman
I already purchased the 4:30 flight out of there. I'm sure I can show up late and get on the next flight, but they may charge me a little extra for that.

Paul Egerman – eScription – CEO
I'm pleased to hear, Joe, that you're going to be there.

Joseph Heyman – AMA – Bord Chairman
Absolutely I'll be there.

Paul Egerman – eScription – CEO
One of the concerns I had a little bit, actually somebody raised, is when I looked at the agenda is that we've been thinking a lot about this from the standpoint of decision support and CPOE and big healthcare organizations. We've also got to look at it from the standpoint of the physician group.

Joseph Heyman – AMA – Bord Chairman
Thank you.

Paul Egerman – eScription – CEO
I just think you have an important perspective to make sure we keep in mind that key point also, so that's very good.

Joseph Heyman – AMA – Bord Chairman
Yes. Again, I applaud ONC for how quickly they were pulled together, just what I think is a pretty darn strong set of panels, so this is great.

Paul Egerman – eScription – CEO

I think ONC deserves to be applauded for a lot of reasons … pulled it all together. Judy has been amazing. I mean, I get these e-mails from her Blackberry, which says, I have no electricity, but here's what we're doing on this thing. And so, she's somehow pulled it all together, and I think she's the only person in Washington, D.C., who actually came in to the office to work together.

Judy Sparrow – Office of the National Coordinator – Executive Director
Maybe not the only one, Paul.

Paul Egerman – eScription – CEO
But I just wanted to say, Judy and the whole ONC staff has been fantastic in pulling this thing together the way they did. Thank you.

Judy Sparrow – Office of the National Coordinator – Executive Director
You're welcome.

Marc Probst – Intermountain Healthcare – CIO
That's it, Paul.

Paul Egerman – eScription – CEO
Are you all set, Marc, on that topic?

Marc Probst – Intermountain Healthcare – CIO
Yes. I think we've got a lot to go through, and I'm with Latanya. Our heads are going to explode.

Paul Egerman – eScription – CEO
In a minute, I'm going to ask for public comment. Before I do that, let me just ask, does anybody have anything else to say, any issue that they want to bring up or anything that wasn't covered that should be? Okay. So let's open to see if there's anybody, any member of the public who would like to make any comments. Can you do that, Judy?

Judy Sparrow – Office of the National Coordinator – Executive Director
Sure. Operator, can you open the line and ask them if anybody wishes to make a comment?

Operator
Yes. (Instructions given) We have no questions or comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Okay. Thank you, operator.

Paul Egerman – eScription – CEO
Great. Thank you. Let me just say thank you to everybody who participated in this call. I know we went through a lot of very detailed stuff on the certification side, and we've got some exciting stuff going on in patient safety. So thank you very much. We've got a lot of work ahead of us.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you … everybody.

Marc Probst – Intermountain Healthcare – CIO
Thanks, Paul.

Judy Sparrow – Office of the National Coordinator – Executive Director
Bye-bye.

Paul Egerman – eScription – CEO
Take care.

M
Bye-bye.